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"A Glimpse of the Future of Health Care in America"
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Introduction

It's a pleasure to be with you all here today.

I've been asked to address a daunting subject: the future of health care in America, particularly in regard to the all important issue of access.

I'd like to be able to paint a bright picture. In a country as rich and blessed as ours, in a country where we pay what we hope is more than lip service to the equality of all persons, in a time when we all know the tremendous value of health care–it seems nearly inconceivable that we would continue to accept a situation where some 40 million people do not have health care coverage.

And yet, unless we show more will and commitment as a nation than we have to date, I fear not only will this situation continue, but in many ways will get worse.

Changes that are occurring

Before we talk specifically about access issues, though, I'd like to just mention a number of areas where our health system and the milieu it operates in is changing. All of them have an affect on coverage and access issues, sometimes direct, and sometimes less so. But all of them are relevant.

Drug and technology issues. First, anyone considering the future of health care can not help but be in awe of the potential before us for developments in treatment of diseases.

We only need to look at the tremendous changes that have occurred over the last ten years or so. With computers, diagnostic tools of great sophistication, and minimally invasive surgery procedures that let us do heart surgery without stopping the heart, major abdominal surgery with only the smallest of incisions, surgery on fetuses to correct birth defects before they happen–much has changed

in the way we are able to treat serious and life threatening medical conditions.

Nowhere is the promise greater than in the area of drug therapies. With the development of the biotechnology industry, with the increasing promise of being able to use gene therapy to cure genetic diseases, with the knowledge of the human genome which may allow us to design regiments of treatment to address individualized situations, with the tremendous promise of stem cell research in treatment of diseases like Parkinson's and juvenile diabetes–the possibilities are truly staggering.

And yet we face the likelihood that as more and more incredible tools become available to us, fewer and fewer will be able to afford them. Certainly people without health care coverage at all will find these treatments and technologies unaffordable. A growing gulf between what medicine can do for people and who is able to actually get access to these miracles seems inevitable.

Privacy concerns. Additionally, while it might not seem directly related, all of these developments are going to increasingly impinge on the privacy of health care information that people have a right to want and expect.

The more we are able to identify genes that lead to disease, the more important it will become not only to protect the privacy of that information, but to protect against discrimination against the person who carries these markers. Job discrimination–and health insurance discrimination–on the basis of the identification of knowledge that a person carries a genetic disposition toward certain conditions can have devastating effects in terms of coverage and access to care.

And lest we think this is unlikely, we only need to look at various current practices of the insurance industry.

We see managed care plans in Medicare skimming the population looking for better health care risks. We see barriers to coverage of preexisting conditions particularly in the individual health insurance market.

We see a breakdown in many ways in the concept of insurance. We only need to look at the controversy that occurs whenever community rating is under discussion: truly spreading the risk raises the premiums for healthier people already covered, so the argument grows.

If we think we have problems in all these areas now–and we do–think of the potential when we can identify ahead of time a genetic predisposition to high-cost conditions and diseases.

Even without the complications caused by this kind of knowledge, in this computer age, we face today problems with protecting the basic privacy of an individual's health care information.

The more we know about an individual's health situation, the more valuable that information becomes to companies, like drug companies for one, in marketing their products. Being able to target populations and push certain products can be worth millions. Frankly, I think we've just seen a demonstration about how great these pressures are going to be with the changes the Administration is proposing in the privacy protection rules that were developed at the end of the Clinton Administration. It's an ominous warning.

Health care work force issues. We also see significant changes occurring in health care in terms of our health care work force.

I've spent years in Washington working on health care, but I have never seen a time when so many physicians are indicating to me that they are ready to get out of the business. I use that word "business" loosely, but maybe with good reason. The constant complaint I hear is that health care has become very much a business.

This is clearly a problem in the area of managed care, where we know well the complaints physicians have with that system. Probably the greatest impetus behind the push for the Patients' Bill of Rights that has dominated the legislative agenda in Washington the last few years has been the increasing concern by both patients and medical professionals that decisions were being made not based on the health needs of the patient but on the bottom line of the health care plan.

Now you know and I know that none of us can be oblivious to the problem of the high costs of medical care. The days when businesses, insurers or the government will or should write a blank check are long gone.

But there is a fine line between appropriate efforts to control costs and making costs the primary determinant of care. If we lose the confidence of the public that their health care needs are the primary concern , whether by their

managed care plan or their insurer, then we are going to be in serious trouble in this country.

Further, the shortage of nurses is a situation that has reached critical proportions.

This is clearly a problem in hospitals. And the results of shortages of staff cause many ripple effects. We end up with capacity in the hospital being unavailable because it cannot be staffed. Few free beds means problems in the emergency rooms. If you can't move people out of the emergency room, you can't take additional cases in. That results in diversions of people critically in need of care from one hospital emergency room to another. This isn't, as they say, the way to run a railroad.

But severe as the problem is in the hospital setting, it is even worse, I believe, in nursing homes. As they frequently tell me, they are at the end of the chain in being able to hire nursing staff. And that has very serious implications.

I've worried for a long time about problems of abuse and low quality care in some nursing homes. Study after study shows that we have severe and unacceptable problems in too many homes–not all, certainly, but in too many. And when you look into the issue, it is invariably a question of not having enough trained nursing staff.

Failure to solve this problem has serious implications that affect our whole health care system.

Bioterrorism. As if all these problems weren't enough, we now have the additional pressures caused by the recent bioterrorist attacks, and the increasing awareness of the potential of bioterrorists using agents like small pox, anthrax, and various agents that can have catastrophic health effects.

All of this has brought into sharp focus a number of problems.

First and foremost, it has made us overwhelmingly aware of the level to which we have allowed our public health infrastructure in this country to deteriorate. We are quite simply woefully unprepared to respond to the kinds of threats we now face.

We have taken some action as a result, sending some Federal monies into States and local areas to improve our capacity to respond. But the job before us is enormous.

Further, looking at the potential for biological warfare, has heightened our awareness of the need to develop and have available vaccines to deal with these threats. There has been a lot of focus on small pox, and we are desperately working to be fully prepared for that.

But the whole crisis has brought increasing focus on many of the difficulties we already face in developing and producing vaccines.

The plain fact is that fewer and fewer companies want to make them. And in the case of vaccines designed to be available in the case of bioterrorist attacks–hopefully ones that will not have to be used–we face additional challenges in getting the industry to put resources into their production and development.

Aging of the population; health care costs. All of these issues have implications for our health care future. But perhaps most relevant of all when we consider issues of access are what I call the two basic facts: we have an aging population, and we again are facing an era of rising health care costs.

Both of these place demands and constraints on the system which make it hard to extend and improve coverage.

Access to health care

So let's talk about what we face in the future in terms of access to health care.

First, we have again over 40 million people in this country without health care coverage.

Second, as we all know, the basic place people get their health care coverage in this country is through an employer-based insurance. That might not be a perfect system–or indeed the one we would design if we could start over from scratch, but it's what we've got. And we'd better not start doing things to undermine it.

Since we do rely on employer based coverage, it's obvious that the people who don't have coverage are people who that system fails for one reason or another:

–they are not employed, either because they can't find a job, or they are too young or old to have one, or they've lost their employment

–they work for an employer who doesn't provide health care coverage, or they don't cover the dependents of their employees

–they are disabled, and working or not, they don't get coverage of the services they need.

What we do know about the uninsured is that about 80% of them are in working families, and nearly two-thirds of them are low-income persons or from low-income families. Almost 11 million are children.

And while some of these people may opt not to take available employer coverage, the large proportion of them can't get coverage. They either have to try to buy it in the individual insurance market–which essentially doesn't work for people with health care problems, or they have to rely on publicly-financed health care programs. Or they go without.

As you know, there are many gaps in our public health insurance programs.

We have Medicare and we have Medicaid.

Both of those programs already face severe financial pressures, and both of them need improvement and expansion.

Medicare. Medicare has been with us since 1965. It covers seniors and disabled persons. It originally developed because of the failure of the private health insurance system to serve these groups.

Since its inception it's been an enormously popular program that has been as critical as Social Security is itself in bringing financial security to seniors.

Since its expansion in the early 1970s to cover the disabled and persons with renal disease, however, the changes that have occurred in Medicare have

been in benefits, delivery mechanisms, and provider payments and coverage. It has not been expanded to help address the problem of other people without health care coverage.

Many of us who would like to see universal coverage in this country might prefer that we take the simple and obvious step of extending Medicare to all, whether by slowly dropping the age of coverage to younger and younger groups, or by extending it to kids and "aging" coverage up until everyone is covered.

But we are not even close to a serious consideration of such a step.

What we could do, and should do, is at least extend Medicare to spouses of Medicare eligibles who frequently end up without coverage now, to early retirees, and to people over 55 who either lose their jobs or their employer-sponsored retirement coverage.

Those changes, all at the margin of Medicare, if you will, would make a very significant contribution to a group that is currently frequently left uninsured and likely to be in desperate need of health care coverage.

While there is no immediate promise of action on the horizon, I do believe this is a step that is feasible and sensible to consider.

Of course, the Medicare program itself is currently the source of hot debate. There is near universal agreement that we need prescription drug coverage for the Medicare population. The days are long past when prescription drugs can be seen as an adjunct to a basic medical care plan: they are a vital piece.

Recognizing that I'm generalizing a bit here, I would say the current situation in Washington is that Democrats believe we must add a universal and comprehensive prescription drug benefit into Medicare, available to all beneficiaries whether they are in Medicare+Choice plans or traditional fee-for-service. That is the "reform" of Medicare that people want and need.

Republicans, on the other hand, want to offer prescription drug coverage through private insurance or managed care plans, and they want to link it to a reform of Medicare which is designed to move people into private plans.

This represents a very basic and fundamental difference in view about what

Medicare should be. They want to turn it into a so-called defined contribution plan: limit the Medicare exposure to a certain level of financial contribution and let people have choices in the private market. Democrats want to keep Medicare as a defined benefit plan, so Medicare beneficiaries can depend on the services that will be covered, whether they are sick or healthy.

As you might guess, it's a lively debate, and one that is very fundamental in terms of the public responsibility to its seniors.

Medicaid. Let's turn for a moment to Medicaid.

As you know, this program is also designed to provide coverage to people who would otherwise by uninsured. It in fact covers more Americans than Medicare, and in terms of total Federal and State dollars spent on the program, is just about to surpass Medicare in size.

Over 40 million people are enrolled in Medicaid–1 in 7 Americans. The program provides coverage to low-income families and children, disabled persons, and low-income Medicare beneficiaries. It is often linked with the SCHIP program, designed to work either through or in conjunction with Medicaid to extend coverage to uninsured low-income children above poverty.

This is a program that we know works in terms of reducing the numbers of uninsured.

Yet we see little on the horizon that makes it likely or feasible that we will see expansions of Medicaid or other public programs to bring the coverage that we so clearly need.

That is not for lack of trying. I'm one of the sponsors of legislation to expand SCHIP to cover the parents of those low-income kids, and I favor extending its coverage to all low-income uninsured. But to do it is going to require the commitment of additional resources.

One of the worst things we could do would be to extend eligibility but not put in any more money. This is what the Administration is attempting through a series of waivers of Medicaid requirements. While nobody would dispute the need to cover more uninsured people, asking the poorest of the poor to in effect finance it by giving up some of their coverage is not a sensible way to go.

We've got to recognize that we need to increase the Federal commitment of dollars for coverage.

State budgets are strained by what they already have on their plate. And the aging of the population that gets so much attention in the Medicare context poses an equally daunting challenge in Medicaid which only adds to the financial problem the States face.

Few know it, but Medicaid is *the* payer for long-term care in this country. In fact, it pays for considerably more than half of all nursing home care.

At first that seems strange, since Medicaid is a program for poor people. But the fact is, if you end up in a nursing home, and spend very long there, if you're like most people, you're going to end up poor. Few can sustain their own costs for long.

Medicare pays for very little long-term care, a fact that few people seem really aware of until they need coverage. And private long-term care insurance still remains relatively rare.

And incidentally, just as an aside, it is my personal belief that private long-term care insurance is never going to be the answer here–at least for most people. To make it affordable, you really have to start paying for it when you're relatively young–a time when there are a lot of other demands on income, and the need for long-term care seems pretty remote.

But even if you get over that part of the problem, it means you'll be paying for a private policy for years before you are likely to use it. That makes it critical that long-term care policies contain certain basic elements: inflation protection and nonforfeiture features. Further, people need to know that the premium they pay is not going to increase over time until it becomes unaffordable. Because if it does, just when they need the policy, they'll find they can't keep paying for it.

The problem is though, when you put all these features in place, the premium increases dramatically, and it is less likely people will buy it. So while it's worth seeing what contribution private coverage can make, in the end, in my view, it will never be the answer.

So unless we find the will–and the money–to include real long-term care

coverage in Medicare, or a social insurance program like Medicare–the burden will continue to fall on Medicaid.

And the implications of that burden for State budgets will continue to limit expansions of coverage of more traditional health insurance to the uninsured.

My own view is that Medicaid, for all its problems, is and remains the single most effective program we've got for reaching the population that for whatever reason doesn't get their health care coverage through an employer sponsored plan.

And it is probably unsustainable without a higher level of Federal support.

The most immediate thing we need to do, in my view, is increase the Federal matching rate, so that the Federal government bears a greater proportion of the cost of the program. But that has continually been met with resistance by the Republicans in Congress and the Administration. It is obvious that in the foreseeable future, any greater commitment of resources to Medicaid to improve and extend its coverage is going to be extremely difficult to obtain.

Tax credits. I just want to make one more comment before we leave this question of access.

One of the ideas that seems to be in vogue among my Republican colleagues in Washington is to give people tax credits and tell them to go out and get insurance for themselves. In almost all circumstances, I think this is a bad idea.

First, it's a very inefficient way of trying to reduce the number of uninsured. A lot of the dollars get spent giving tax credits to people who already have coverage. That might be nice from some equity point of view, but given our limited resources and the desperate need to reduce the number of uninsured, we can spend our dollars a lot more effectively elsewhere.

Second, it puts people into the individual health insurance market to find their coverage. That is the worst thing we could do. It might offer affordable coverage to people who are basically healthy, but heaven help you if you have a health problem. It doesn't even take a major health problem to make coverage unaffordable. Asthma can be enough to do it.

Third, it actually is likely to undermine the availability of employer-sponsored coverage. Our first rule here should be: first do no harm. Breaking down the one part of our system which is providing coverage to people and sending more people into the individual market is the last thing we should be doing.

Fourth, almost every tax credit scheme suggested doesn't provide people with enough of a subsidy to make it work. But even if it did, to even begin to be workable it would imply a regulation of the individual health insurance market far beyond what is ever going to be politically achievable.

Direct coverage. I do want to make it clear that I don't think health access is only a condition of having health insurance coverage.

I know there is great work done by community health centers, clinics and public health professionals.

But even they can not carry on their work without support from third party payors. Ultimately, without insurance coverage, most people are going to have limited access, and most providers of care aren't going to be able to deliver services.

Conclusion

In concluding, let me just say that I know I have painted a bleak picture today. Maybe that's because the political situation in Washington has left me particularly pessimistic about addressing the access problem.

But this doesn't have to be what the future looks like. We are a rich country. It's not a question of resources, it's a question of priorities. If we have the will, we can find the way to provide health care coverage for all Americans.

I look forward to having all of you join me in that fight.